Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005846	A. BUILDING: _____ B. WING _____	C 07/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS ASSISTED LIVING	**7833 W JEFFERSON BLVD FORT WAYNE, IN 46804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00131569. Complaint IN00131569 Substantiated No deficiencies related to the allegations are cited. Survey date: July 8, 2013 Facility number: 005846 Provider number: 005846 AIM number: NA Survey team: Christine Fodrea, RN, TC Census bed type: Residential: 80 Total: 80 Census payor type: Other: 80 Total: 80 Sample: 3 Coventry Meadows Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN 00131569. Quality Review 07/09/13 by Lisa McColly	R 000		